Financial Institution Reimbursement Request

Rev 05/04

State of Utah
Department of Human Services
Office of Recovery Services/Child Support Services
FM03

Reimbursement request date: _____

***NOTE: Reimbursement requests must be submitted within 45 days of the end of the quarter. Reimbursements received after this period will not be paid.**

Quarter in which cost was incurred: (check one)

1st Quarter: _____ (Jan, Feb, Mar) 2nd Quarter: _____ (Apr, May, June) 3rd Quarter: _____ (July, Aug, Sept) 4th Quarter: _____ (Oct, Nov, Dec)

Institution Name ***TIN/EIN***

Address ***Telephone***

Contact Name ***Telephone***

Service Agent Name ***TIN/EIN***

Address ***Telephone***

Contact Name ***Telephone***

Service Agent's Signature: (person authorized to request reimbursement match) **Date:**

Actual Cost of Match: $

*** NOTE: ORS WILL REIMBURSE UP TO $150 PER QUARTER**

Date Approved_____Approved by _____Date to Financial Svs._____

Return this form to: Attention: Tiffeni Wall Office of Recovery Services, P.O. Box 45011, SLC, UT 84145
Phone (801)536-8902 Fax: (801) 536-8509 E-mail: orsfidm@utah.gov